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| **WHO** on the team needs access to the data?*Examples: Practice staff, clinicians, practice facilitator, patients* |  |
| **WHAT** data does the team need?*Examples: measures, reports, graphs, numerator/denominator definitions* |  |
| **WHY** is this data meaningful to the practice’s improvement efforts? |  |
| **WHEN** will the team:* Access the data (get the reports)?
* Review the data (look at and discuss the data)?
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| **WHERE** will the team access the data:* Within the organization?
* Within PTI (if applicable)?

*\*Do they have permissions, logins, passwords, training, etc.?* |  |
| **HOW** will the team sustain access to and review of the data after the practice facilitator departs? |  |
| **HOW** will the team act upon the data? *Examples: Conduct or adapt a PDSA, monitor process measures, contact patients on care gap report to schedule appointments* |  |
| *Consider*: **WHICH** change interventions are adopted, in testing, or planned? 1. Implement standing orders for staff to order and administer HbA1c test
2. Provide in-house HbA1c testing and EHR documentation workflow
3. Conduct care team huddles to identify care gap opportunities.
4. Implement panel management in-reach:
	1. Schedule patients for appointments per evidence-based clinical guidelines
	2. Ensure patients show for appointments
5. Use a disease registry or similar EHR functionality to query and produce care gap reports for integration into huddles.
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